OASIS ITEM:

(M0440) Does this patient have a **Skin Lesion** or an **Open Wound**? This excludes "OSTOMIES."

☐ 0 - No **[If No, go to *M0490*]**
☐ 1 - Yes

DEFINITION:

Identifies the presence of a skin lesion or open wound. A lesion is a broad term used to describe an area of pathologically altered tissue. Sores, skin tears, burns, ulcers, rashes, surgical incisions, crusts, etc. are all considered lesions. All alterations in skin integrity are considered to be lesions, except alterations that end in "ostomy" (e.g., tracheostomy, gastrostomy, etc.) or peripheral IV sites. Persistent redness without a break in the skin is also considered a lesion.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient has any skin condition which should be observed and described, mark "Yes" to this item.
- Only certain types of wounds are described by specific OASIS items, but other wounds (e.g., burns, diabetic ulcers, wounds caused by trauma of various kinds, etc.), should be documented in a manner determined by each agency. You may mark "1 – Yes" to this item and correctly mark "No" to questions M0445 (Pressure Ulcer), M0468 (Stasis Ulcer), and M0482 (Surgical Wound), if the patient has a different type of wound.
- Pin sites, central lines, PICC lines, implanted infusion devices or venous access devices, surgical wounds with staples or sutures, etc. are all considered lesions/wounds.
- There are many types of "ostomies," all of which involve a surgically formed opening from outside the body to an internal organ or cavity. A suprapubic tube site is a cystostomy; an ileal conduit opens in an ileostomy; etc. All "ostomies" are excluded from consideration under this item.

ASSESSMENT STRATEGIES:

Interview the patient to determine the existence of any known lesions. Follow by visual inspection of the skin. Inspection may reveal additional areas on which to focus interview questions. The comprehensive assessment should include additional documentation of lesion/wound location, size, appearance, status, drainage, etc., if applicable.

OASIS ITEM:

(M0445) Does this patient have a **Pressure Ulcer**?

☐ 0 - No **[If No, go to *M0468*]**
☐ 1 - Yes

DEFINITION:

Identifies the presence of a pressure ulcer, defined as any lesion caused by unrelieved pressure resulting in tissue hypoxia and damage of the underlying tissue. Pressure ulcers most often occur over bony prominences.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to an inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Answer this question "Yes" if this patient has a pressure ulcer at any stage. (See OASIS item M0450 for definitions of pressure ulcers by stage.) Answer "No" if the patient's skin lesion is any other kind of ulcer or wound.

ASSESSMENT STRATEGIES:

Interview for the presence of risk factors for pressure ulcers (i.e., immobility, activity limitations, skin moisture or incontinence, poor nutrition, limited sensory-perceptual ability). Inspect the skin over bony prominences carefully.

It is important to differentiate pressure ulcers from other types of skin lesions.

OASIS ITEM:

(M0450) Current Number of Pressure Ulcers at Each Stage: (Circle one response for each stage.)

Pressure Ulcer Stages		Number of Pressure Ulcers				
a)	Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators.	0	1	2	3	4 or more
b)	Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.	0	1	2	3	4 or more
c)	Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.	0	1	2	3	4 or more
d)	Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.)	0	1	2	3	4 or more
e)	In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? ☐ 0 - No ☐ 1 - Yes					

DEFINITION:

Identifies the number of pressure ulcers at each stage present at the time of assessment. Definitions of pressure ulcer stages derive from the National Pressure Ulcer Advisory Panel.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Circle the number of ulcers appropriate for each stage.
- If there are NO ulcers at a given stage, circle “0” for that stage.
- Mark a response for each part of this item: a), b), c), d), and e).
- A pressure ulcer covered by eschar or a nonremovable cast or dressing, cannot be staged, and "yes" should be selected for response (e).
- A muscle flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer. It <u>does not</u> become a surgical wound.

ASSESSMENT STRATEGIES:

Inspect the skin over bony prominences carefully, particularly for patients with known risk factors for pressure ulcers. (See M0445 for listing of risk factors.)

Recognizing erythema (a Stage 1 ulcer) in darker-skinned individuals requires close examination. Inspect for change in texture, a bluish/purplish skin tone, or extremely dry skin in areas over bony prominences. Palpate for warmth, tissue consistency (firm or boggy feel), or slight edema in these areas. Interview for sensation changes (pain, itching).

The bed of the ulcer must be visible to accurately determine the stage. If the bed of the pressure ulcer is covered by necrotic tissue (slough or eschar), it cannot be staged until the necrotic tissue is removed.

Reverse staging of granulating pressure ulcers is NOT an appropriate clinical practice according to the National Pressure Ulcer Advisory Panel (NPUAP). If a pressure ulcer is Stage 3 at SOC and is granulating at the follow-up visit, the ulcer remains a Stage 3 ulcer. If the patient has been in an inpatient setting for some time, it is conceivable that the wound has already started to granulate, thus making it impossible to know the stage of the wound at its worst. The clinician should make every effort to contact previous providers (including patient’s physician) to determine the stage of the wound at its worst. An ulcer's stage can worsen, and this item should be answered appropriately if this occurs.
Consult published guidelines of NPUAP (www.npuap.org) for additional clarification and/or resources for training.

OASIS ITEM:

(M0460)* Stage of Most Problematic (Observable) Pressure Ulcer:

☐ 1 - Stage 1
☐ 2 - Stage 2
☐ 3 - Stage 3
☐ 4 - Stage 4
☐ NA - No observable pressure ulcer

*At Follow-up, following the item number (M0460), insert the phrase "skip this item if patient has no pressure ulcers."

DEFINITION:

Identifies the most problematic pressure ulcer of those noted in M0450. “Most problematic” may be the largest, the most advanced stage, the most difficult to access for treatment, the most difficult to relieve pressure, etc., depending on the specific situation.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient has only one pressure ulcer, then that ulcer is the most problematic.
- In evaluating the most problematic ulcer, do not include any ulcer to which response “e” in M0450 applied. If that is the only ulcer, mark “NA.”
- Insert directions at follow-up to skip this item if the patient has no pressure ulcer(s).
- "Nonobservable" pressure ulcers include only those that cannot be observed due to the presence of eschar or a nonremovable dressing (see M0450).

ASSESSMENT STRATEGIES:

Incorporate the information from M0450 and the status of each pressure ulcer and utilize clinical reasoning to determine the most problematic (observable) ulcer.

OASIS ITEM:

(M0464) Status of Most Problematic (Observable) Pressure Ulcer:

☐ 1 - Fully granulating
☐ 2 - Early/partial granulation
☐ 3 - Not healing
☐ NA - No observable pressure ulcer

DEFINITION:

Identifies the degree of healing visible in the ulcer identified in M0460 as the most problematic observable pressure ulcer.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Mark the response which most accurately describes the healing process you see occurring in the most problematic pressure ulcer (identified in M0460).
- A Stage 1 pressure ulcer or an infected pressure ulcer is not healing (Response 3).
- A pressure ulcer that is covered by necrotic tissue (eschar) cannot be staged, but its status is not healing.
- If part of the ulcer is covered by necrotic tissue, then it is not healing (Response 3).
- "Nonobservable" pressure ulcers include only those that cannot be observed due to the presence of a nonremovable dressing, including casts.

ASSESSMENT STRATEGIES:

Visualization of the wound is necessary to identify the degree of healing evident in the ulcer identified in M0460.

OASIS ITEM:

(M0468) Does this patient have a **Stasis Ulcer**?

☐ 0 - No **[If No, go to *M0482*]**
☐ 1 - Yes

DEFINITION:

Identifies the presence of an ulcer caused by inadequate venous circulation in the area affected (usually lower legs). This lesion is often associated with stasis dermatitis.

Stasis ulcers do not include arterial circulatory lesions or arterial ulcers.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

ASSESSMENT STRATEGIES:

Interview for presence of circulatory disorders and lower extremity skin change in the past health history. Inspect the skin carefully, especially the lower extremities.

It is important to differentiate stasis ulcers from other types of skin lesions.

OASIS ITEM:

(M0470) Current Number of Observable Stasis Ulcer(s):

- ☐ 0 - Zero
- ☐ 1 - One
- ☐ 2 - Two
- ☐ 3 - Three
- ☐ 4 - Four or more

DEFINITION:

Identifies the number of visible (observable) stasis ulcers.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

"Non-observable" stasis ulcers include only those that are covered by a nonremovable dressing.

ASSESSMENT STRATEGIES:

Inspect the skin carefully, especially the lower extremities. Count the ulcerations that can be seen.

OASIS ITEM:

(M0474) Does this patient have at least one **Stasis Ulcer that Cannot be Observed** due to the presence of a nonremovable dressing?

☐ 0 - No
☐ 1 - Yes

DEFINITION:

Identifies the presence of a stasis ulcer which is covered by a dressing that home care staff are not to remove (e.g., an Unna's paste-boot).

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

"Non-observable" stasis ulcers include only those that are covered by a nonremovable dressing.

ASSESSMENT STRATEGIES:

The past health history and current referral information provide knowledge of the reason for any nonremovable dressing. Uncertainty regarding the reason for the nonremovable dressing can be resolved through communication with the physician.

OASIS ITEM:

(M0476)* Status of Most Problematic (Observable) Stasis Ulcer:

- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable stasis ulcer

*At Follow-up, following the item number (M0476) insert the phrase "skip this item if patient has no stasis ulcers."

DEFINITION:

Identifies the degree of healing present in the most problematic, observable stasis ulcer. The “most problematic” ulcer may be the largest, the most resistant to treatment, one which is infected, etc., depending on the specific situation.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient has only one stasis ulcer, that ulcer is the most problematic.
- Insert directions at follow-up to skip this item if the patient has no stasis ulcers.
- "Nonobservable" stasis ulcers include only those that are covered by a nonremovable dressing.

ASSESSMENT STRATEGIES:

Inspect each ulcer to determine its status. Based on this information and that from the health history, use clinical reasoning to determine the most problematic (observable) stasis ulcer.

OASIS ITEM:

(M0482) Does this patient have a **Surgical Wound?**

☐ 0 - No **[If No, go to *M0490*]**
☐ 1 - Yes

DEFINITION:

Identifies the presence of any wound resulting from a surgical procedure.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Orthopedic pin sites, central line sites, stapled or sutured incisions, debrided graft sites and wounds with drains are all considered surgical wounds. A surgical incision with approximated edges and a scab (i.e., crust) from dried blood or tissue fluid is considered a current surgical wound.
- Medi-port sites and other implanted infusion devices or venous access devices are considered surgical wounds.
- "Old" surgical wounds that have resulted in scar or keloid formation are not considered current surgical wounds.
- A muscle flap performed to surgically replace a pressure ulcer is a surgical wound and is no longer a pressure ulcer.
- A pressure ulcer that has been surgically debrided remains a pressure ulcer. It does not become a surgical wound.
- A PICC line is not a surgical wound, as it is peripherally inserted, although it is considered a skin lesion (see M0440).

ASSESSMENT STRATEGIES:

If health history or diagnoses indicate recent surgery (including closed reduction and fixation of a fracture), inspect surgical sites.

OASIS ITEM:

(M0484) Current Number of (Observable) Surgical Wounds: (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.)

- ☐ 0 - Zero
- ☐ 1 - One
- ☐ 2 - Two
- ☐ 3 - Three
- ☐ 4 - Four or more

DEFINITION:

Identifies the number of observable surgical wounds.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- A wound is not observable if it is covered by a dressing (or cast) which is not to be removed, per physician's orders.
- Each opening in a single surgical wound is counted as one wound. Examples: (1) Each orthopedic pin site is a separate wound. (2) A vertical laparotomy incision which is partially closed, but has a small opening at the mid-point and another at the distal point would count as two wounds.
- Suture or staple insertion sites are not considered to be separate wounds.

ASSESSMENT STRATEGIES:

Count the number of visible wounds.

OASIS ITEM:

(M0486) Does this patient have at least one **Surgical Wound that Cannot be Observed** due to the presence of a nonremovable dressing?

☐ 0 - No
☐ 1 - Yes

DEFINITION:

Identifies the presence of a surgical wound which is covered by a dressing (or cast) which is not to be removed, per physician's orders.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Answer yes if there is a wound for which the dressing cannot be removed by home care clinicians (e.g., a plastic surgeon may order that he/she is the only one to remove the dressing over a new skin graft).

ASSESSMENT STRATEGIES:

Review referral information; interview patient; inspect surgical site(s). Contact physician if uncertain about removing dressing.

OASIS ITEM:

(M0488)* Status of Most Problematic (Observable) Surgical Wound:

- ☐ 1 - Fully granulating
- ☐ 2 - Early/partial granulation
- ☐ 3 - Not healing
- ☐ NA - No observable surgical wound

*At Follow-up, following the item number (M0488) insert the phrase, "skip this item if patient has no surgical wound(s)."

DEFINITION:

Identifies the degree of healing visible in the most problematic surgical wound. The “most problematic” wound is the one that may be complicated by the presence of infection; location of wound, large size, difficult management of drainage, or slow healing.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Requires identification of the most problematic surgical wound.
- If there is only one surgical wound, the status of that one should be noted.
- Insert directions at follow-up to skip this item if the patient has no surgical wounds(s).
- "Nonobservable" surgical wounds include only those that are covered by a nonremovable dressing (or cast).

ASSESSMENT STRATEGIES:

If there is more than one wound, determine which is the most problematic. Visualize this wound to identify the degree of healing.

OASIS ITEM:

(M0490) When is the patient dyspneic or noticeably **Short of Breath**?

- ☐ 0 - Never, patient is not short of breath
- ☐ 1 - When walking more than 20 feet, climbing stairs
- ☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- ☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- ☐ 4 - At rest (during day or night)

DEFINITION:

Identifies the patient's level of shortness of breath.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient usually uses oxygen continuously, mark the response that best describes the patient's shortness of breath while using oxygen.
- If the patient uses oxygen intermittently, mark the response that best describes the patient's shortness of breath WITHOUT the use of oxygen.
- The responses represent increasing severity of shortness of breath.

ASSESSMENT STRATEGIES:

Request to see the bathroom setup, allowing you the opportunity to observe and evaluate the occurrence of shortness of breath with a walk of a distance you can estimate (if less than 20 feet, ask the patient to extend the distance back to a chair). During conversation with the patient, does he/she stop frequently to catch his/her breath? Review symptoms and their severity in past health history.

OASIS ITEM:

(M0500) Respiratory Treatments utilized at home: **(Mark all that apply.)**

- ☐ 1 - Oxygen (intermittent or continuous)
- ☐ 2 - Ventilator (continually or at night)
- ☐ 3 - Continuous positive airway pressure
- ☐ 4 - None of the above

DEFINITION:

Identifies any of the listed respiratory treatments being used by this patient in the home.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Excludes any respiratory treatments that are not listed in the item (e.g., does not include nebulizers, inhalers, etc.).

ASSESSMENT STRATEGIES:

Interview patient/caregiver. Review referral information and medication orders. Observe for presence of such equipment in the home.

OASIS ITEM:

(M0510) Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Patient on prophylactic treatment
- ☐ UK - Unknown *

* At discharge, omit "UK - Unknown."

DEFINITION:

Identifies treatment of urinary tract infection during the past 14 days.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency – not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If patient had symptoms of a UTI or a positive culture for which the physician did not prescribe treatment, or the treatment ended more than 14 days ago, mark Response 0 – No.
- Answer “Yes” when the patient had a UTI for which the patient received treatment during the past 14 days.
- Note that if the patient is on prophylactic treatment to prevent UTIs, the appropriate response is “NA.”
- If the patient is on prophylactic treatment and develops a UTI, mark Response 1 – Yes.

ASSESSMENT STRATEGIES:

Interview for symptoms and treatment in past health history. Review referral orders. Question the patient about new medications. Confirm with physician if necessary.

OASIS ITEM:

(M0520) Urinary Incontinence or Urinary Catheter Presence:

- ☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[If No, go to *M0540*]**
- ☐ 1 - Patient is incontinent
- ☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[Go to *M0540*]**

DEFINITION:

Identifies presence of urinary incontinence or condition that requires urinary catheterization of any type, including intermittent or indwelling. The etiology (cause) of incontinence is not addressed in this item.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If the patient has anuria or an ostomy for urinary drainage (e.g., an ileal conduit), mark Response 0.
- If the patient is incontinent AT ALL (i.e., “occasionally”, “only once-in-a-while”, “sometimes I leak a little bit”, etc.), mark Response 1.
- If the patient requires the use of a urinary catheter for any reason (retention, post-surgery, incontinence, etc.), mark Response 2.
- If the patient is both incontinent and requires a urinary catheter, mark Response 2 and follow the skip pattern.
- A leaking urinary drainage appliance is not incontinence.

ASSESSMENT STRATEGIES:

Review the urinary elimination pattern as you take the health history. Does the patient admit having difficulty controlling the urine, or is he/she embarrassed about needing to wear a pad so as not to wet on clothing? Do you have orders to change a catheter? Is your stroke patient using an external catheter? Be alert for an odor of urine, which might indicate there is a problem with bladder sphincter control. If the patient receives aide services for bathing and/or dressing, ask for input from the aide (at follow-up assessment). This information can then be discussed with the patient. Urinary incontinence may result from multiple causes, including physiologic reasons, cognitive impairments, or mobility problems.

OASIS ITEM:

(M0530)* When does **Urinary Incontinence** occur?

- ☐ 0 - Timed-voiding defers incontinence
- ☐ 1 - During the night only
- ☐ 2 - During the day and night

*At follow-up, following the item number (M0530) insert the phrase, "skip this item if patient has no urinary incontinence or has a urinary catheter."

DEFINITION:

Identifies the time of day when the urinary incontinence occurs.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- If patient is only “occasionally” incontinent, determine when the incontinence usually occurs.
- Any incontinence that occurs during the day should be marked with Response 2.
- Insert directions at follow-up to skip this item if the patient has no urinary incontinence or has a urinary catheter.

ASSESSMENT STRATEGIES:

Once the existence of incontinence is known, ask when the incontinence occurs.

OASIS ITEM:

(M0540) Bowel Incontinence Frequency:

- ☐ 0 - Very rarely or never has bowel incontinence
- ☐ 1 - Less than once weekly
- ☐ 2 - One to three times weekly
- ☐ 3 - Four to six times weekly
- ☐ 4 - On a daily basis
- ☐ 5 - More often than once daily
- ☐ NA - Patient has ostomy for bowel elimination
- ☐ UK - Unknown *

* At follow-up and discharge, omit "UK - Unknown."

DEFINITION:

Identifies how often the patient experiences bowel incontinence. Refers to the frequency of a symptom (bowel incontinence), not to the etiology (cause) of that symptom. This item does not address treatment of incontinence or constipation (e.g., a bowel program).

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Responses are arranged in order of least to most frequency of bowel incontinence.
- Response “NA” is used if patient has an ostomy for bowel elimination.

ASSESSMENT STRATEGIES:

Review the bowel elimination pattern as you take the health history. Observe the cleanliness around the toilet when you are in the bathroom. Note any visible evidence of soiled clothing. Ask the patient if she/he has difficulty controlling stools, has problems with soiling clothing, uncontrollable diarrhea, etc. The patient’s responses to these items may make you aware of (an as yet unidentified) problem which needs further investigation. If the patient is receiving aide services, question the aide about evidence of bowel incontinence at follow-up time points. This information can then be discussed with the patient. Incontinence may result from multiple causes, including physiologic reasons, mobility problems, or cognitive impairments.

OASIS ITEM:

(M0550) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay,* or b) necessitated a change in medical or treatment regimen?

- ☐ 0 - Patient does not have an ostomy for bowel elimination.
- ☐ 1 - Patient's ostomy was not related to an inpatient stay* and did not necessitate change in medical or treatment regimen.
- ☐ 2 - The ostomy was related to an inpatient stay* or did necessitate change in medical or treatment regimen.

* At discharge, omit references to inpatient facility stay.

DEFINITION:

Identifies whether the patient has an ostomy for bowel elimination and, if so, whether the ostomy was related to a recent inpatient stay or a change in medical treatment plan.

TIME POINTS ITEM(S) COMPLETED:

Start of care
Resumption of care
Follow-up
Discharge from agency - not to inpatient facility

RESPONSE—SPECIFIC INSTRUCTIONS:

- Applies to any type of ostomy for bowel elimination (i.e., colostomy, ileostomy, etc.).
- If patient does not have an ostomy for bowel elimination, the correct response is 0 - Patient does not have an ostomy for bowel elimination.
- If an ostomy has been reversed, then the patient does not have an ostomy at the time of assessment.
- If the patient does have an ostomy for bowel elimination, determine whether the ostomy was related to an inpatient stay or change in the medical or treatment regimen.

ASSESSMENT STRATEGIES:

Unless an ostomy is mentioned in the referral orders, interview the patient about the presence of an ostomy (or you may have done so when responding to M0540). If the patient has such an ostomy, determine by asking the patient or the physician, whether there have been recent problems with the ostomy, which have necessitated an inpatient facility stay or a change in the medical or treatment regimen.